MICHOLANE   MICHOLANE   CHAMPILS   CHAMPIL	IN THIS AREA				°Private °Interper °Immuniza	iodic Scre	eni	ng			
Milestance   1									DRM		PICA
2 PATENTS NAME (LISE Name Per Name, Middle Initial)   3 PATENTS NAME (LISE Name First Name, Middle Initial)   3 PATENTS NAME (LISE Name First Name, Middle Initial)   3 PATENTS NAME (LISE Name First Name, Middle Initial)   3 PATENTS NAME (LISE Name, First Name, Middle Initial)	i .			#) HEALTH PLAN (SSN or ID)	BLK LUNG (SSN) (ID)	1		R		(FOR	PROGRAM IN IT
SAME		ame, Middle Initial)	-0.0.	3 PATIENT'S BIRTH DATE	SEX	4. INSURED'S NAME	E (Last N	łame, Fi	rst Nam	e, Middl	le Initial)
19   Mattel Lane				02 07 1998		3.000,0500					
Relación   NC   Sirgio   Married   Other   20º CODE   TELEPHONE (include Area Code)   Telephone   Part Time   Pa	_					7. INSURED'S ADDR	RESS (N	o., Stree	et)		
20 CODE	CITY			8. PATIENT STATUS		CITY					STATE
20   10   10   10   10   10   10   10			Single Married	7IP CODE		ITC	EBUO	NE (INC	CLUDE ABEA CO		
1   STATIENTS CONDITION RELATED TO   1   1   INSURED'S POLICY OR GROUP OR FECA NUMBER   2   EMPLOYMENT? (CURRENT OR PREVIOUS)   2   INSURANCE PLANT NAME OR SCHOOL NAME   5   NO						Zir GODE		'5	(	)	LUDE AREA CU
STATE   SOURCE   SATE OF BIRTH   SEX   M						11. INSURED'S POL	ICY GRO	OUP OR	FECA I	NUMBE	Я
VES	a. OTHER INSURED'S POLICY OR GRO	UP NUMBER		a. EMPLOYMENT? (CURRE	NT OR PREVIOUS)	a. INSURED'S DATE	OF BIR	ТН			SEY
C. EMPLOYER'S NAME OR SCHOOL NAME				YES	NO					м	F []
C. CHER ACCIDENT?  OF IND  OF	MM . DD YY					b. EMPLOYER'S NAP	ME OR S	СНОО	NAME		
INSURANCE PLAN NAME OR PROGRAM NAME			-	·		c. INSURANCE PLAN	NAME	OR PRO	GRAM	NAME	11 14
12   PATIENT'S OR AUTH-ORIZED PERSON SIGNATURE   authorize the release of any medical or other information nocessary between the party and sometimes and supported by the process this claim. I also request seyment of government benefits effect to reyeld to the party and society assignment of potential and request seyment of government benefits effect to reyeld to the party and society assignment of potential and request seyment of government benefits effect to reyeld to the party and society assignment of potential benefits to the undersigned physician or supposed to the party and society assignment of potential benefits to the undersigned physician or supposed to the party and society assignment of potential benefits to the undersigned physician or supposervices described below.    I											
12 PATIENTS OR AUTHORIZED FERSONS SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment between the services described below.    14 DATE	d. INSURANCE PLAN NAME OR PROGR	RAM NAME		10d. RESERVED FOR LOCA	L USE				-		
to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.    Signed	READ BACK O	F FORM BEFORE C	OMPLETING	& SIGNING THIS FORM.	-dti	13. INSURED'S OR A	UTHOR	IZED PE	RSON"	S SIGN	ATURE I authorize
14	to process this claim. I also request pay	ment of government b	enefits either	o myself or to the party who ac	cepts assignment	payment of medica services described	al benefi d below.	ts to the	undersi	gned ph	nysician or supplie
14 DATE OF CURRENT				DATE		SIGNED					
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE   17a. LD. NUMBER OF REFERRING PHYSICIAN   18. NOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM   D0   YY	14. DATE OF CURRENT: A ILLNESS (I	First symptom) OR	15. 1	PATIENT HAS HAD SAME O	OR SIMILAR ILLNESS.	16. DATES PATIENT	UNABLE	TO W	ORK IN	CURRE	NT OCCUPATION
19. RESERVED FOR LOCAL USE  20. OUTSIDE LAB?  20. OUTSIDE LAB?  21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1.2.3 OR 4 TO ITEM 24E BY LINE)  22. LEDICAID RESUBMISSION OF SERVICE TO BE OF PROCEDURES. SERVICES. OR SUPPLIES (Explain Unusual Cicumstances)  24. A	PREGNAN	ICY(LMP)	179	00 00	0000	FROM TALIZATIO				_	i t
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21. L_V70 3.    2	19. RESERVED FOR LOCAL USE								\$ CHA	ARGES	
1. LV70 3.  22. L	21. DIAGNOSIS OR NATURE OF ILLNES	S OR INJURY. (RELA	TE ITEMS 1,	2,3 OR 4 TO ITEM 24E BY LIF	NE)			N			
24. A D E F G H I J J KENDERS SERVICES OF SUPPLIES DIAGNOSIS CODE SCHARGES DAYS FEBOT OR FAMILY DAYS SERVICES OF SUPPLIES OF S	1. L <b>V70</b> .,.3.		3.		+					IEF. NO	).
24						23. PRIOR AUTHORIZ	ZATION	NUMBE	R		
MM   DD   YY   MM   DD   YY   Service   Service   Service   CEPplain Unusual Circumstances   CODE   SCHARGES   UNITS   Filan   EMG   COB   RESOLUTION   CODE   CO	2.1		PROCEDURA		E	F				J	
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(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)  PLEASE PRINT OR TYPE  APPROVED OMB-938-0008 FORM CMS-1500 (12-90). FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001	24. A POATE(S) OF SERVICE_TO FORM DD YY MM DD  12. 05 02 12.05 00  12. 05 02 12.05 00  12. 05 02 12.05 00  12. 05 02 12.05 00  12. 05 02 12.05 00  12. 05 02 12.05 00  12. 05 02 12.05 00  12. 05 02 12.05 00  12. 05 02 12.05 00  13. 05 02 12.05 00  14. 05 02 12.05 00  15. FEDERAL TAXID. NUMBER SS  31. SIGNATURE OF PHYSICIAN OR SUPP INCLUDING DEGREES OR GREEDEN INC	YY Service Service 2 11 2 11 2 11 2 11 2 11 2 11 2 11 2	90471 90472 90700 90713 90707 ATIENT'S AC	EP 27. ACCE (For go YES) DRESS OF FACILITY WHER other than home or office)	NO SERVICES WERE	0 00  0 00  28 TOTAL CHARGE  107 7  33 PHYSICIANS, SUP  A PHONE * K.C  Hea  Ral	1 1 1 2 2 C. Coalth eigh	s BILLIN MMUN Star Star	G NAME ity I t Rd 276	E. ADDF Hæal: 00 39010	\$ 107 these streets are considered the considered t